FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0023739

Facility Name: A.H. PARTNERSHIP D/B/A ABBOTT HOUSE

Address: 405 CENTRAL AVENUE (Number) HIGHLAND PARK (City) 60035 (Zip Code)

County: LAKE

Telephone Number: (847) 432-6080 **Fax #** (847) 432-7286

IDPA ID Number: 36-2948048001

Date of Initial License for Current Owners: 12/15/77

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) SEE ACCOUNTANT'S REPORT ATTACHED (Date)

(Print Name and Title) ROBERT A. ROSE, C.P.A.

(Firm Name & Address) FROST, RUTTENBERG & ROTHBLATT, P.C.
111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number A.H. PARTNERSHIP D/B/A ABBOTT HOUSE # 0023739 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	106	Intermediate (ICF)	106	38,796	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	106	TOTALS	106	38,796	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	0				8
9	SNF/PED					9
10	ICF	33,447	2,486	778	36,711	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	33,447	2,486	778	36,711	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.63%

D. How many bed-hold days during this year were paid by Public Aid?
849 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/15/77

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number A.H. PARTNERSHIP D/B/A ABBOTT HOUS # 0023739 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	201,961	6,265	5,264	213,490		213,490		213,490			1
2	Food Purchase		144,339		144,339		144,339	(98)	144,241			2
3	Housekeeping	126,953	19,792		146,745		146,745		146,745			3
4	Laundry	48,417	8,728		57,145		57,145		57,145			4
5	Heat and Other Utilities			58,776	58,776		58,776	398	59,174			5
6	Maintenance	87,908		87,036	174,944		174,944	(3,036)	171,908			6
7	Other (specify):*											7
8	TOTAL General Services	465,239	179,124	151,076	795,439		795,439	(2,736)	792,703			8
	B. Health Care and Programs											
9	Medical Director			2,400	2,400		2,400		2,400			9
10	Nursing and Medical Records	588,636	37,120	4,706	630,462		630,462	(15,869)	614,593			10
10a	Therapy			2,888	2,888		2,888		2,888			10a
11	Activities	130,804	13,355		144,159		144,159		144,159			11
12	Social Services	28,436	1,512	3,912	33,860		33,860		33,860			12
13	Nurse Aide Training			1,076	1,076		1,076		1,076			13
14	Program Transportation			3,289	3,289		3,289		3,289			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	747,876	51,987	18,271	818,134		818,134	(15,869)	802,265			16
	C. General Administration											
17	Administrative	84,627		324,848	409,475		409,475	(192,598)	216,877			17
18	Directors Fees											18
19	Professional Services			90,058	90,058		90,058	(7,581)	82,477			19
20	Dues, Fees, Subscriptions & Promotions			51,950	51,950		51,950	(25,405)	26,545			20
21	Clerical & General Office Expenses	75,782	29,492	35,957	141,231		141,231	(16,328)	124,903			21
22	Employee Benefits & Payroll Taxes			185,177	185,177		185,177	1,343	186,520			22
23	Inservice Training & Education											23
24	Travel and Seminar			15,033	15,033		15,033	(10,864)	4,169			24
25	Other Admin. Staff Transportation			1,980	1,980		1,980		1,980			25
26	Insurance-Prop.Liab.Malpractice			29,112	29,112		29,112	100	29,212			26
27	Other (specify):*							4,939	4,939			27
28	TOTAL General Administration	160,409	29,492	734,115	924,016		924,016	(246,394)	677,622			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,373,524	260,603	903,462	2,537,589		2,537,589	(264,999)	2,272,590			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

A.H. PARTNERSHIP D/B/A ABBOTT HOUSE
0023739
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS		
2		FOOD	

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX		
19		PROFESSIONAL FEES	

To reclass cost of appealing real estate taxes

Facility Name & ID Number A.H. PARTNERSHIP D/B/A ABBOTT HOUSE #0023739 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			29,319	29,319		29,319	10,225	39,544			30
31	Amortization of Pre-Op. & Org.			9,420	9,420		9,420	(9,420)				31
32	Interest			5,669	5,669		5,669	(5,669)				32
33	Real Estate Taxes			50,380	50,380		50,380		50,380			33
34	Rent-Facility & Grounds							3,496	3,496			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			94,788	94,788		94,788	(1,368)	93,420			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		25,851		25,851		25,851	(25,851)				41
42	Provider Participation Fee			58,194	58,194		58,194		58,194			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		25,851	58,194	84,045		84,045	(25,851)	58,194			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,373,524	286,454	1,056,444	2,716,422		2,716,422	(292,218)	2,424,204			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number A.H. PARTNERSHIP D/B/A ABBOTT HOUSE # 0023739 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	9,635	30		9
10	Interest and Other Investment Income	(5,669)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(98)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(9)	21		18
19	Entertainment				19
20	Contributions	(550)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(9,255)	21		24
25	Fund Raising, Advertising and Promotional	(1,920)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(6,853)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(97,921)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (112,640)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(179,578)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (179,578)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (292,218)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

A.H. PARTNERSHIP D/B/A ABBOTT HOUSE

ID# 0023739

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$	6	1
2	VETERAN'S PRESCRIPTION DRUGS	(9,226)	10	2
3	VETERAN LABORATORY CHARGES	(656)	10	3
4	VETERAN PHYSICIAN CHARGES	(5,987)	10	4
5	PROMOTION	(12,180)	20	5
6	PROMOTION-MEALS	(10,685)	20	6
7	TRUST FEES	(100)	20	7
8	COPE DUES	(176)	20	8
9	AMORTIZATION OF GOODWILL	(9,420)	31	9
10	ADDDITIONAL LEGAL FEES NOT BOOKED	6,517	19	10
11	NONALLOWABLE ACCOUNTING FEES	(13,487)	19	11
12	OFFSET B. ROSENBAUM SALARY & INS	(1,813)	21	12
13	OUT OF STATE TRAVEL	(2,269)	24	13
14	NON ALLOWABLE SEMINAR EXPENSE	(8,595)	24	14
15	PRIOR PERIOD LEGAL FEES	(957)	19	15
16	VENDING INCOME	(25,851)	41	16
17	CAPITALIZED REPAIR & MAINT	(3,036)	6	17
18				18
19				19
20				20
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89				89
90	Total	(97,921)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number A.H. PARTNERSHIP D/B/A ABBOTT HOUSE # 0023739 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses A. General Services	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(98)											(98)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			398									398	5
6	Maintenance	(3,036)											(3,036)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(3,134)		398									(2,736)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(15,869)											(15,869)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(15,869)											(15,869)	16
	C. General Administration													
17	Administrative			(15,000)		(73,202)	(104,396)						(192,598)	17
18	Directors Fees													18
19	Professional Services	(7,927)		127		131	88						(7,581)	19
20	Fees, Subscriptions & Promotions	(25,611)		206									(25,405)	20
21	Clerical & General Office Expenses	(17,930)		1,602									(16,328)	21
22	Employee Benefits & Payroll Taxes			1,343									1,343	22
23	Inservice Training & Education													23
24	Travel and Seminar	(10,864)											(10,864)	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			100									100	26
27	Other (specify):*					3,009	1,930						4,939	27
28	**TOTAL General Administration**	(62,332)		(11,622)		(70,062)	(102,378)						(246,394)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(81,335)		(11,224)		(70,062)	(102,378)						(264,999)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number A.H. PARTNERSHIP D/B/A ABBOTT HOUSE # 0023739 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	9,635		590									10,225	30
31	Amortization of Pre-Op. & Org.	(9,420)											(9,420)	31
32	Interest	(5,669)											(5,669)	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds			3,496									3,496	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	**TOTAL Ownership**	(5,454)		4,086									(1,368)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops	(25,851)											(25,851)	41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**	(25,851)											(25,851)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(112,640)		(7,138)		(70,062)	(102,378)						(292,218)	45

Facility Name & ID Number A.H. PARTNERSHIP D/B/A ABBOTT HOUSE # 0023739 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number A.H. PARTNERSHIP D/B/A ABBOTT HOUSE # 0023739 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$ 0	A.H.B. D/B/A ABH MANAGEMENT	100.00%	$ 398	$ 398	15
16	V	19	PROFESSIONAL FEES	0	A.H.B. D/B/A ABH MANAGEMENT	100.00%	127	127	16
17	V	20	DUES, SUBS. & FEES	0	A.H.B. D/B/A ABH MANAGEMENT	100.00%	206	206	17
18	V	21	CLERICAL AND GENERAL	0	A.H.B. D/B/A ABH MANAGEMENT	100.00%	1,602	1,602	18
19	V	22	EMPLOYEE BENEFITS	0	A.H.B. D/B/A ABH MANAGEMENT	100.00%	1,343	1,343	19
20	V	26	INSURANCE	0	A.H.B. D/B/A ABH MANAGEMENT	100.00%	100	100	20
21	V	30	DEPRECIATION	0	A.H.B. D/B/A ABH MANAGEMENT	100.00%	590	590	21
22	V	34	RENT	0	A.H.B. D/B/A ABH MANAGEMENT	100.00%	3,496	3,496	22
23	V	0		0			0		23
24	V	0		0			0		24
25	V	17	HOME OFFICE	15,000	A.H.B. D/B/A ABH MANAGEMENT	100.00%	0	(15,000)	25
26	V	0		0			0		26
27	V	0		0			0		27
28	V	0		0			0		28
29	V	0		0			0		29
30	V	0		0			0		30
31	V	0		0			0		31
32	V	0		0			0		32
33	V	0		0			0		33
34	V	0		0			0		34
35	V	0		0			0		35
36	V	0		0			0		36
37	V	0		0			0		37
38	V	0		0			0		38
39	Total			$ 15,000			$ 7,862	$ * (7,138)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number A.H. PARTNERSHIP D/B/A ABBOTT HOUSE # 0023739 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADM. COMP.- DIRECT ALLOC.	$	A.H.B. D/B/A ABH MANAGEMENT	100.00%	$ 0	$	15
16	V	27	EMP. BEN.-DIRECT ALLOC.		A.H.B. D/B/A ABH MANAGEMENT	100.00%	0		16
17	V	0					0		17
18	V	0					0		18
19	V	0					0		19
20	V	0					0		20
21	V	0					0		21
22	V	0					0		22
23	V	0					0		23
24	V	0					0		24
25	V	0					0		25
26	V	0					0		26
27	V	0					0		27
28	V	0							28
29	V	0							29
30	V	0					0		30
31	V	0					0		31
32	V	0					0		32
33	V	0					0		33
34	V	0							34
35	V	0		0					35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number A.H. PARTNERSHIP D/B/A ABBOTT HOUSE # 0023739 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3	4	5	6	7	8	
	Schedule V		Line	Cost Per General Ledger Item	Amount	Cost to Related Organization Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		17	ADMIN. - KARLA BISHOP	$	KARLA BISHOP, INC.	100.00%	$ 82,500	$ 82,500	15
16	V		19	PROFESSIONAL FEES		KARLA BISHOP, INC.	100.00%	131	131	16
17	V		27	PAYROLL TAXES		KARLA BISHOP, INC.	100.00%	3,009	3,009	17
18	V		0					0		18
19	V		17	MANAGEMENT FEES	155,702	KARLA BISHOP, INC.	100.00%	0	(155,702)	19
20	V		0					0		20
21	V		0					0		21
22	V		0					0		22
23	V		0					0		23
24	V		0					0		24
25	V		0					0		25
26	V		0					0		26
27	V		0					0		27
28	V		0							28
29	V		0							29
30	V		0					0		30
31	V		0					0		31
32	V		0					0		32
33	V		0					0		33
34	V		0							34
35	V		0							35
36	V									36
37	V									37
38	V									38
39	Total				$ 155,702			$ 85,640	$ * (70,062)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number A.H. PARTNERSHIP D/B/A ABBOTT HOUSE # 0023739 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMIN. - E. ROSENBAUM	$	HEALTH RESOURCE, INC.	100.00%	$ 49,750	$ 49,750	15
16	V	19	PROFESSIONAL FEES		HEALTH RESOURCE, INC.	100.00%	88	88	16
17	V	27	PAYROLL TAXES		HEALTH RESOURCE, INC.	100.00%	1,930	1,930	17
18	V	0					0		18
19	V	17	MANAGEMENT FEES	154,146	HEALTH RESOURCE, INC.	100.00%	0	(154,146)	19
20	V	0					0		20
21	V	0					0		21
22	V	0					0		22
23	V	0					0		23
24	V	0					0		24
25	V	0					0		25
26	V	0					0		26
27	V	0					0		27
28	V	0					0		28
29	V	0					0		29
30	V	0					0		30
31	V	0					0		31
32	V	0					0		32
33	V	0					0		33
34	V	0					0		34
35	V	0					0		35
36	V	0					0		36
37	V	0					0		37
38	V	0					0		38
39	Total			$ 154,146			$ 51,768	$ * (102,378)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number A.H. PARTNERSHIP D/B/A ABBOTT HOUSE # 0023739 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number A.H. PARTNERSHIP D/B/A ABBOTT HOUSE # 0023739 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number A.H. PARTNERSHIP D/B/A ABBOTT HOUSE # 0023739 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number A.H. PARTNERSHIP D/B/A ABBOTT HOUSE # 0023739 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number A.H. PARTNERSHIP D/B/A ABBOTT HOUSE # 0023739 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number A.H. PARTNERSHIP D/B/A ABBOTT HOU # 0023739 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Earl Rosenbaum	General Partner	Admin/Bookkeep	36.55	See Attached	10	25.00	Admin Salary	$ 49,750	17-7	1
2	Karla Bishop	General Partner	Administrative	10.15	See Attached	15	37.50	Admin Salary	82,500	17-7	2
3	Ivy Shenkman	Administrator	Administrative	4.23	None	40	100.00	Salary	84,627	17-1	3
4	Mitchell Rosenbaum	Maintenance	Maintenance	0.00	None	40	100.00	Salary	54,681	6-1	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 271,558		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number A.H. PARTNERSHIP D/B/A ABBOTT HOUSE # 0023739 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number A.H. PARTNERSHIP D/B/A ABBOTT HOUSE # 0023739 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: A.H.B. D/B/A ABH MANAGEMENT
Street Address: 411 CENTRAL AVENUE
City / State / Zip Code: HIGHLAND PARK, IL. 60035
Phone Number: ((847)432-7262
Fax Number: ((847)432-6095

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	143,433	3	$ 1,554	$	36,711	$ 398	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	143,433	3	495		36,711	127	2
3	20	DUES, SUBS. & FEES	PATIENT DAYS	143,433	3	807		36,711	206	3
4	21	CLERICAL AND GENERAL	PATIENT DAYS	143,433	3	6,260		36,711	1,602	4
5	22	EMPLOYEE BENEFITS	PATIENT DAYS	143,433	3	5,247		36,711	1,343	5
6	26	INSURANCE	PATIENT DAYS	143,433	3	392		36,711	100	6
7	30	DEPRECIATION	PATIENT DAYS	143,433	3	2,305		36,711	590	7
8	34	RENT	PATIENT DAYS	143,433	3	13,660		36,711	3,496	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 30,720	$		$ 7,862	25

Facility Name & ID Number A.H. PARTNERSHIP D/B/A ABBOTT HOUSE # 0023739 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: A.H.B. D/B/A ABH MANAGEMENT
Street Address: 411 CENTRAL AVENUE
City / State / Zip Code: HIGHLAND PARK, IL. 60035
Phone Number: ((847)432-7262
Fax Number: ((847)432-6095

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADM. COMP.- DIRECT ALLOC	AVG. HOURS WORKED	40	1	11,340				1
2	27	EMP. BEN.-DIRECT ALLOC.	AVG. HOURS WORKED	40	1	2,260				2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 13,600	$		$	25

Facility Name & ID Number A.H. PARTNERSHIP D/B/A ABBOTT HOUSE # 0023739 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: KARLA BISHOP, INC.
Street Address: 271 RIVERS DRIVE
City / State / Zip Code: LAKE BLUFF, IL. 60044
Phone Number: ((847)432-7262
Fax Number: ((847)432-6095

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMIN. - KARLA BISHOP	AVG. HOURS WORKED	40	3	$ 220,000	$ 220,000	15	$ 82,500	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED	40	3	350		15	131	2
3	27	PAYROLL TAXES	AVG. HOURS WORKED	40	3	8,025		15	3,009	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 228,375	$ 220,000		$ 85,640	25

Facility Name & ID Number A.H. PARTNERSHIP D/B/A ABBOTT HOUSE # 0023739 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: HEALTH RESOURCE, INC.
Street Address: P.O. BOX 1275
City / State / Zip Code: HIGHLAND PARK, IL. 60035
Phone Number: ((847)432-7262
Fax Number: ((847)432-6095

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMIN. - E. ROSENBAUM	AVG. HOURS WORKED	40	3	$ 199,000	$ 199,000	10	$ 49,750	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED	40	3	350		10	88	2
3	27	PAYROLL TAXES	AVG. HOURS WORKED	40	3	7,720		10	1,930	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 207,070	$ 199,000		$ 51,768	25

Facility Name & ID Number A.H. PARTNERSHIP D/B/A ABBOTT HOUSE # 0023739 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number A.H. PARTNERSHIP D/B/A ABBOTT HOUSE # 0023739 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number A.H. PARTNERSHIP D/B/A ABBOTT HOUSE # 0023739 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number A.H. PARTNERSHIP D/B/A ABBOTT HOUSE # 0023739 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number A.H. PARTNERSHIP D/B/A ABBOTT HOUSE # 0023739 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number A.H. PARTNERSHIP D/B/A ABBOTT HOU # 0023739 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	SUCCESS BANK		X	AUTO LOAN	$1,410.00	2/9/98	44,790	2,791			852	6
7	EARL ROSENBAUM	X			$1,138.00	1/2/98	45,000	15,916			1,920	7
8	KARLA BISHOP	X			$1,138.00	2/9/98	45,000	15,916			1,920	8
9	TOTAL Facility Related				$3,686.00		$ 134,790	$ 34,623			$ 4,692	9
	B. Non-Facility Related*											
10	Supplemental Schedule							73,993			(4,692)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$ 73,993			$ (4,692)	14
15	TOTALS (line 9+line14)						$ 134,790	$ 108,616			$ 0	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number A.H. PARTNERSHIP D/B/A ABBOTT HOUSI # 0023739 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	American National Bank		X	Finance Construction	1,538.74	11/06/00	$ 75,000	$ 73,993	11/06/05	8.50%	$ 977	1
2	Interest Income										(5,669)	2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$ 75,000	$ 73,993			$ (4,692)	21

Facility Name & ID Number A.H. PARTNERSHIP D/B/A ABBOTT HOUSE # 0023739 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	47,271	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	47,635	2
3. Under or (over) accrual (line 2 minus line 1).	$	364	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	50,017	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	50,381	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	38,548	8
	1996	39,501	9
	1997	44,102	10
	1998	45,020	11
	1999	47,635	12

$47,635 X 1.05=$50,017

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.** This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number A.H. PARTNERSHIP D/B/A ABBOTT HOUSE # 0023739 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			1977	$ 58,752	1
2					2
3	TOTALS			$ 58,752	3

Facility Name & ID Number A.H. PARTNERSHIP D/B/A ABBOTT HOUSE # 0023739 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	106		1977	1977	$ 822,936	$		$	$	$ 822,936	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10	Various			1977	12,036		20			12,036	10
11	Various			1978	686		20			686	11
12	Various			1979	13,652		20			13,652	12
13	Various			1980	12,137		20			12,137	13
14	Various			1981	391		20			391	14
15	Various			1982	442		20			442	15
16	Various			1983	1,570		20			1,570	16
17	Various			1984	6,914	147	20	163	16	6,654	17
18	Various			1985	16,470	856	20	867	11	13,221	18
19	Various			1986	41,754	2,171	20	2,197	26	31,926	19
20	Various			1989	13,333	423	20	667	244	7,698	20
21	Various			1990	1,458		20			1,458	21
22	Various			1991	5,843	185	20	69	(116)	690	22
23	Various			1992	20,907	663	20	1,046	383	9,087	23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33	PAGE 12C TOTALS				35,837	320		1,147	827	1,360	33
34	PAGE 12B TOTALS				66,982	1,869		3,351	1,482	9,145	34
35	PAGE 12A TOTALS				215,915	5,740		8,150	2,410	45,276	35
36	TOTAL (lines 4 thru 35)				$ 1,289,263	$ 12,374		$ 17,657	$ 5,283	$ 990,365	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number A.H. PARTNERSHIP D/B/A ABBOTT HOUSE # 0023739 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	58,704	1,995	20	2,935	940	21,542	9
10	Various			1994	21,039	416	20	793	377	5,031	10
11	Various			1995	26,190	635	20	704	69	4,800	11
12	Garage Ceiling			1996	2,922	75	20	75		341	12
13	Garage Ceiling			1996	1,210	31	20	31		138	13
14	Water Fountain			1996	1,033	26	20	26		118	14
15	Garage Ceiling			1996	554	14	20	14		64	15
16	Pump Motor Repair			1996	917	24	20	24		97	16
17	Roof-Deposit			1996	1,970	51	20	51		232	17
18	Roof-Architect			1996	405	10	20	10		45	18
19	Elevator Repair-Dep			1996	2,851	73	20	73		332	19
20	New Roof			1996	9,975	256	20	256		1,120	20
21	Elevator			1996	14,255	366	20	366		1,571	21
22	Bath Remodeling			1996	1,050	27	20	27		116	22
23	Boiler Repair			1996	3,176	81	20	81		334	23
24	Plumbing			1996	2,583	66	20	66		272	24
25	Elevator Upgrade			1996	11,404	292	20	292		1,229	25
26	Boiler Part Replaced			1996	3,210	82	20	82		407	26
27	New Windows			1996	1,580	41	20	41		196	27
28	Dumbwaiter Repair			1997	1,654		20	83	83	249	28
29	Telephone Equipment			1997	3,270		20	164	164	873	29
30	Window Replacements			1997	9,587	246	20	479	233	1,477	30
31	Carpeting			1997	3,364	86	20	168	82	588	31
32	Smoke Detectors			1997	7,958	204	20	398	194	1,592	32
33	Window Replacements			1998	6,417	165	20	321	156	883	33
34	Window Replacements			1998	14,037	360	20	360		1,035	34
35	Window-D.C.			1998	4,600	118	20	230	112	594	35
36	TOTAL (lines 4 thru 35)				$ 215,915	$ 5,740		$ 8,150	$ 2,410	$ 45,276	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number A.H. PARTNERSHIP D/B/A ABBOTT HOUSE # 0023739 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Telehone System			1998	3,270		20	164	164	1,432	9
10	Window Replacement			1998	11,017	282	20	551	269	1,561	10
11	Window-K.C.			1998	12,572	322	20	629	307	1,520	11
12	Dumbwaiter Door			1998	1,325	34	20	66	32	138	12
13	Window-K.C.			1998	5,000	128	20	250	122	646	13
14	Window-Northern			1998	1,500	38	20	75	37	188	14
15	Electrical			1998	790	20	20	40	20	97	15
16	Emergency Lights			1998	940	24	20	47	23	110	16
17	Doors			1998	2,286	59	20	114	55	266	17
18	Window Replacement			1998	3,415	88	20	171	83	442	18
19	Steel Doors			1998	1,346	35	20	67	32	156	19
20	Emergency Station SH			1998	650	17	20	33	16	69	20
21	Windows-Northern			1998	1,500	38	20	75	37	194	21
22	Computer Hardware			1998	2,030	390	20	102	(288)	440	22
23	HVAC Control			1998	964	25	20	48	23	112	23
24	Fire Alarm			1998	529		20	26	26	59	24
25	Window Replacement			1998	6,417	165	20	321	156	856	25
26	Security System			1999	2,125	54	20	106	52	141	26
27	Carpeting			1999	650	17	20	33	16	50	27
28	Painting & Decorating			1999	1,645	42	20	82	40	123	28
29	Elevator Repair			1999	1,450	37	20	73	36	140	29
30	Carpeting			1999	678	17	20	34	17	68	30
31	Construction			1999	1,429	37	20	71	34	107	31
32	Waterball Valve			1999	1,126		20	56	56	61	32
33	Carpet			1999	650		20	33	33	50	33
34	Pressure Valve			1999	1,143		20	57	57	81	34
35	Securtiy Camera			1999	535		20	27	27	38	35
36	TOTAL (lines 4 thru 35)				$ 66,982	$ 1,869		$ 3,351	$ 1,482	$ 9,145	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number A.H. PARTNERSHIP D/B/A ABBOTT HOUSE # 0023739 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Doors/Windows			1999	1,430		20	72	72	108	9
10	Wallcovering			1999	1,150		20	58	58	87	10
11	Conduits/Cable			1999	610		20	31	31	49	11
12	Plumbing			1999	1,469		20	73	73	110	12
13	Carpet			1999	678		20	34	34	68	13
14	Thermostat			1999	527		20	26	26	39	14
15	Conduit & Cable			1999	610	16	20	31	15	52	15
16	Wallcovering			1999	748		20	37	37	62	16
17	Shower Room Tile			2000	1,000	25	20	50	25	50	17
18	Carpet			2000	818	15	20	31	16	31	18
19	Concrete Walks			2000	11,224	156	20	327	171	327	19
20	Water Heater			2000	3,884	54	20	113	59	113	20
21	Bathroom Remodeling			2000	1,423	17	20	36	19	36	21
22	New Circuitry			2000	1,998	6	20	17	11	17	22
23	Flooring Tile			2000	723	7	20	15	8	15	23
24	Boiler Repair			2000	4,509	24	20	56	32	56	24
25	Sprinkler			2000	715		20	33	33	33	25
26	Plumbing			2000	1,671		20	77	77	77	26
27	Hot Water Tank			2000	650		20	30	30	30	27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 35,837	$ 320		$ 1,147	$ 827	$ 1,360	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number A.H. PARTNERSHIP D/B/A ABBOTT HOUSE # 0023739 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number A.H. PARTNERSHIP D/B/A ABBOTT HOUSE # 0023739 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number A.H. PARTNERSHIP D/B/A ABBOTT HOUSE # 0023739 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number A.H. PARTNERSHIP D/B/A ABBOTT HOUSE # 0023739 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number A.H. PARTNERSHIP D/B/A ABBOTT HOUSE # 0023739 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
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22											22
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24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number A.H. PARTNERSHIP D/B/A ABBOTT HOUSE # 0023739 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
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24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number A.H. PARTNERSHIP D/B/A ABBOTT HOUSE # 0023739 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
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21											21
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25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number A.H. PARTNERSHIP D/B/A ABBOTT HOUSE # 0023739 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
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18											18
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number A.H. PARTNERSHIP D/B/A ABBOTT HOUSE # 0023739 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number A.H. PARTNERSHIP D/B/A ABBOTT HOUSE # 0023739 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 163,679	$ 3,221	$ 15,319	$ 12,098		$ 85,241	37
38	Current Year Purchases	11,235	10,781	543	(10,238)		543	38
39	Fully Depreciated Assets	245,283	583	3,075	2,492		245,214	39
40								40
41	TOTALS	$ 420,197	$ 14,585	$ 18,937	$ 4,352		$ 330,998	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Facility Business	Lexus	1998	$ 65,529	$ 2,950	$ 2,950	$	5	$ 11,110	42
43										43
44										44
45										45
46	TOTALS			$ 65,529	$ 2,950	$ 2,950	$		$ 11,110	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 1,833,741	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 29,909	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 39,544	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 9,635	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,332,473	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58	Remodeling	$ 60,500	58
59			59
60			60
61		$ 60,500	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

A.H. PARTNERSHIP D/B/A ABBOTT HOUSE
0023739
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

LINE 28: PRIOR YEARS

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
A.H. PARTNERSHIP	158,822	2,832	14,833	12,001	83,340
ABH MANAGEMENT	4,857	389	486	97	1,901
TOTALS	163,679	3,221	15,319	12,098	85,241

LINE 29: CURRENT YEAR

A.H. PARTNERSHIP	10,668	10,668	496	(10,172)	496
ABH MANAGEMENT	567	113	47	(66)	47
TOTALS	11,235	10,781	543	(10,238)	543

LINE 30: FULLY DEPRECIATED

A.H. PARTNERSHIP	236,234	495	2,974	2,479	236,234
ABH MANAGEMENT	9,049	88	101	13	8,980
TOTALS	245,283	583	3,075	2,492	245,214

TOTALS (Should Tie to Totals on Page 13)

A.H. PARTNERSHIP	405,724	13,995	18,303	4,308	320,070
ABH MANAGEMENT	14,473	590	634	44	10,928
TOTALS	420,197	14,585	18,937	4,352	330,998

Facility Name & ID Number A.H. PARTNERSHIP D/B/A ABBOTT HOUSE # 0023739 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions	Allocated from ABH Management			3,496			4
5								5
6								6
7	TOTAL				$ 3,496 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number A.H. PARTNERSHIP D/B/A ABBOTT HOUSE # 0023739 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	
IN OTHER FACILITY	
COMMUNITY COLLEGE	X
HOURS PER AIDE	

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	
IN OTHER FACILITY	
HOURS PER AIDE	

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$ 590	$ 393	$ 983
2	Books and Supplies		93		93
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 683	$ 393	$ 1,076
10	SUM OF line 9, col. 1 and 2 (e)	$ 683			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	3
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	3

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number A.H. PARTNERSHIP D/B/A ABBOTT HOUSE # 0023739 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	N/A	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number **A.H. PARTNERSHIP D/B/A ABBOTT HOUSE** **# 0023739** **Report Period Beginning:** **01/01/00** **Ending:** **12/31/00**

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1	Medical Supplies	
2	Complex Medical Equip	
3	Oxygen	
4	Equipment Rental	
5		
6		
7		
8		
9		
10		

	Outside Therapies (Column 5 - Other)	Amount
1	Respiratory Therapy	
2		
3		
4		
5		
6		
7		
8		
9		
10		

STATE OF ILLINOIS

Facility Name & ID Number A.H. PARTNERSHIP D/B/A ABBOTT HOUSE # 0023739 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 142,113	$	1
2	Cash-Patient Deposits	60,612		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	559,544		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	38,992		6
7	Other Prepaid Expenses	21,180		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See supplemental schedule			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 822,441	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	58,752		13
14	Buildings, at Historical Cost	1,237,827		14
15	Leasehold Improvements, at Historical Cost	25,500		15
16	Equipment, at Historical Cost	502,486		16
17	Accumulated Depreciation (book methods)	(1,389,829)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	88,784		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 523,520	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,345,961	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 129,891	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	60,330		28
29	Short-Term Notes Payable	40,616		29
30	Accrued Salaries Payable	53,443		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,265		31
32	Accrued Real Estate Taxes(Sch.IX-B)	50,017		32
33	Accrued Interest Payable	1,199		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 347,761	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	68,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 68,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 415,761	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 930,200	$ #REF!	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,345,961	$ #REF!	48

***(See instructions.)**

Facility Name & ID Number A.H. PARTNERSHIP D/B/A ABBOTT HOUSE **#** 0023739 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 12/31/00

OTHER CURRENT ASSETS:	Amount	Amount	OTHER CURRENT LIABILITIES:	Amount	Amount
Real Estate Tax Escrow			Accrued Expenses		
			Accrued R. E. Tax - Non Care Property		
OTHER NON CURRENT ASSETS:			OTHER NON CURRENT LIABILITIES:		
Construction In Progress	60,500				
Goodwill	37,704				
Amoritzation of Goodwill	(9,420)				
	88,784				

Facility Name & ID Number A.H. PARTNERSHIP D/B/A ABBOTT HOUSE **#** 0023739 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 811,538	1
2	Restatements (describe):		2
3	Schedule attached		3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 811,538	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	553,662	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(435,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 118,662	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 930,200	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number	A.H. PARTNERSHIP D/B/A ABBOTT #	0023739	Report Period Beginning:	01/01/00	Ending:	12/31/00

Balance per General Ledger		811,538
Adjustments:		
		-
		-
		-
Total adjustments		-
Balance - Beginning of Year		811,538
Equity(Deficit) from Page 17 Col 1		930,200
Related Party		
Equity(Deficit)	0	
Income	0	
		-
Combined Equity - End of Year		930,200

Facility Name & ID Number A.H. PARTNERSHIP D/B/A ABBOTT HOUSE # 0023739 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,228,136	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,228,136	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	31,079	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 31,079	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	10,869	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 10,869	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,270,084	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	795,439	31
32	Health Care	818,134	32
33	General Administration	924,016	33
	B. Capital Expense		
34	Ownership	94,788	34
	C. Ancillary Expense		
35	Special Cost Centers	25,851	35
36	Provider Participation Fee	58,194	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,716,422	40
41	**Income before Income Taxes (line 30 minus line 40)****	553,662	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 553,662	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number **A.H. PARTNERSHIP D/B/A ABBOT** **# 0023739** **Report Period Beginning:** **01/01/00** **Ending:** **12/31/00**

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/00

	DESCRIPTION	AMOUNT
1	Vending Commissions	
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
	TOTALS	

Facility Name & ID Number A.H. PARTNERSHIP D/B/A ABBOTT HOUSE # 0023739 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,096	2,377	$ 50,990	$ 21.45	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,568	8,902	145,404	16.33	3
4	Licensed Practical Nurses	7,485	7,893	127,418	16.14	4
5	Nurse Aides & Orderlies	22,263	23,896	264,824	11.08	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	12,499	13,351	130,804	9.80	10
11	Social Service Workers	1,601	1,686	28,436	16.87	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,652	19,212	201,961	10.51	15
16	Dishwashers					16
17	Maintenance Workers	7,981	8,676	87,908	10.13	17
18	Housekeepers	11,527	13,015	126,953	9.75	18
19	Laundry	4,172	4,727	48,417	10.24	19
20	Administrator	2,160	2,630	84,627	32.18	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,226	8,225	75,782	9.21	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	104,230	114,590	$ 1,373,524 *	$ 11.99	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	111	$ 5,264	1-3	35
36	Medical Director	96	2,400	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	103	4,586	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	55	2,888	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	75	3,912	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	440	$ 19,050		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	8	120	10-3	52
53	TOTAL (lines 50 - 52)	8	$ 120		53

Facility Name & ID Number A.H. PARTNERSHIP D/B/A ABBOTT HOUSE # 0023739 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
		$	$
0	0	$ 0	$ #DIV/0!

Facility Name & ID Number A.H. PARTNERSHIP D/B/A ABBOTT HOUSE # 0023739 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
IVY SHENKMAN	ADMINISTRATOR	4.23	$ 84,627
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 84,627

B. Administrative - Other

Description		Amount
KARLA BISHOP, INC.	ADMINISTRATIVE	$ 155,702
ABH MANAGEMENT	MANAGEMENT	15,000
HEALTH RESOURCES, INC.	BOOKKEEPING	39,900
HEALTH RESOURCES, INC.	MANAGEMENT	114,246
TOTAL (agree to Schedule V, line 17, col. 3)		$ 324,848
(Attach a copy of any management service agreement)		

C. Professional Services

Vendor/Payee	Type	Amount
FROST, RUTTENBERG	ACCOUNTING	$ 57,035
L. WEBER	COMPUTER CONSULTANT	1,279
ALPHA DATA	DATA PROCESSING	2,179
A.I. HEALTHCARE	LEGAL	5,000
JANE OSA	PENSION ADMINISTRATION	1,470
HOLLEB & COFF	LEGAL	1,838
WINSTON & STRAWN	LEGAL	715
SACHNOFF & WEAVER	LEGAL	20,095
TENNEY & BENTLEY	LEGAL	448
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 90,059

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 18,827
Unemployment Compensation Insurance	11,176
FICA Taxes	102,205
Employee Health Insurance	31,903
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE UNIFORMS	4
UNION HEALTH & WELFARE	8,609
EMPLOYEE MEALS (NET)	564
HOLIDAY EXPENSE	11,889
ALLOCATED FROM ABH MANAGEMENT	1,343
TOTAL (agree to Schedule V, line 22, col.8)	$ 186,520

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	10,949
Health Care Worker Background Check	
(Indicate # of checks performed 17)	204
DUES & SUBSCRIPTIONS	9,518
DUES-ILLINOIS COUNCIL	2,937
LICENSES & FEES	2,731
ALLOCATED FROM ABH MGMT	206
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 26,545

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 2,269
ADJUSTED OUT	(2,269)
In-State Travel	
Seminar Expense	4,169
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,169

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number A.H. PARTNERSHIP D/B/A ABBOTT HOUSE # 0023739 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number A.H. PARTNERSHIP D/B/A ABBOTT HOUSE # 0023739 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **Illinois Council on Long Term Care $3,113**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **217** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **58,194**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **N/A** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **NO** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%ln14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.